



Brief Report

Frequency and impact of childhood sexual and physical abuse on people using IAPT services

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Objectives. This study explored the prevalence of childhood sexual/physical abuse (CSA/CPA) as identified by practitioners in Improving Access to Psychological Therapies (IAPT) services and clarified differences in clients' characteristics with and without a history of CSA/CPA.

Methods. A retrospective analysis of a large dataset comprised of IAPT routine data and data from a local service evaluation reporting on clients' presenting problems.

Results. 14% of IAPT clients ($n = 1,315$) were identified with a record of CSA/CPA. CSA/CPA history was associated with longer duration and earlier age of onset of condition(s), greater number of presenting problems and post-traumatic stress disorder co-occurrence, higher intensity treatment delivery, and lower recovery rates.

Conclusions. CSA/CPA history appears as an important feature in a sizable minority of IAPT clients; further work is required to meet clients' trauma-related needs.

Practitioner points

- A sizable minority of IAPT clients (14%) present with a history of CSA/CPA as recorded in clinical notes.
- CSA/CPA history is associated with more complex and enduring presentations in IAPT clients.
- The reported CSA/CPA frequency is likely to be underestimates of the actual prevalence and impact of adverse childhood experiences in IAPT clients.
- Trauma-informed inquiry and trauma-specific screening tools would help practitioners to meet clients' trauma-related needs.

Adverse childhood experiences (ACEs) are distressing experiences that include one-off incidents and prolonged adversity, such as physical, sexual, or emotional abuse, neglect,

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bereavement, or parental separation. Research indicates that the majority of people who use mental health services have been exposed to ACEs (Mauritz, Goossens, Draijer, & van Achterberg, 2013); however, ACEs do not always lead to post-traumatic stress disorder (PTSD). Multiple meta-analyses have also demonstrated a robust association between ACEs and other mental health difficulties including depression (Mandelli, Petrelli, & Serretti, 2015; Nelson, Klumpp, Doebler, & Ehling, 2017), anxiety (Lindert et al., 2014), obsessive-compulsive disorder (OCD; Miller & Brock, 2017) suicidal behaviour (Zatti et al., 2017) and self-harm (Liu, Cheek, & Nestor, 2016).

Meta-analyses show that people who have experienced ACEs tend to have lower recovery rates and less symptom reduction during depression treatment (Nanni, Uher, & Danese, 2012). Less research is available on the impact of ACEs on anxiety treatment. A longitudinal study ($N = 1,209$) has shown childhood abuse has a similar impact on anxiety treatment and clinical course (Hovens et al., 2012).

In England, the Improving Access to Psychological Therapies (IAPT) programme provides evidence-based treatments to more than 0.6 m people per year with common mental health difficulties, including depression and anxiety disorders (NHS Digital, 2020). The IAPT programme promotes a stepped care model, in which clients receive low-intensity treatment (e.g., guided self-management) or high-intensity treatment (e.g., Cognitive Behavioural Therapy) depending upon the perceived level of need (National Institute for Health and Care Excellence; NICE, 2004). Only a small number of studies have investigated the prevalence of adverse or potentially traumatic life experiences in IAPT clients.

In one study ($N = 54$), over three-quarters of IAPT users reported traumatic experiences (Thomlinson, Muncer, & Dent, 2017); another ($N = 147$) found that two-thirds reported at least one form of childhood trauma, and 55% had experienced at least one threatening event in the past year (Hepgul et al., 2016). An additional study examining IAPT treatment outcome across numerous diagnoses (including OCD, panic, social anxiety, depression, generalized anxiety disorder) found that treatment non-response was associated with higher rates of adverse life experiences (Fischer et al., 2018).

It is unclear how often IAPT practitioners detect ACEs as part of their routine clinical practice, or how often the impact of ACEs represents the primary focus of therapy sought by IAPT users. Further research considering larger samples of IAPT users is needed to build on these findings and evaluate with more precision the prevalence and impact of ACEs within IAPT services.

This study examined how often IAPT practitioners identify a history of childhood sexual abuse and/or physical abuse (CSA/CPA) amongst clients' presenting problems, and compared the demographics (gender, age, and employment status), clinical characteristics (duration of condition, age of onset, number of presenting problems, and PTSD co-occurrence) and assigned treatments and outcomes (number of attended appointments, recommended intervention and intensity of treatment received, recovery, and reliable improvement rates at discharge) of clients with and without identified history of CSA/CPA.

Method

Procedure & participants

The study was a retrospective analysis of IAPT routine data along with data from a local service evaluation, merged into one dataset using unique case IDs. The aforementioned service evaluation took place in three clinical commissioning groups (CCG) areas at the North West of England, in June 2017. All IAPT practitioners providing care in three North West areas were asked to consult their clinical notes and provide further information for

each client on their active caseload (see Appendix). Data were collected from 1,816 current IAPT clients. Clients with incorrect or missing case IDs ($n = 377$), clients who did not meet the criteria for clinical caseness at entry to treatment ($n = 78$) and those who were still under treatment ($n = 46$) at the time of the subsequent outcome analysis (i.e., July 2018) were excluded, leaving 1,315 discharged cases in the final cohort.

Ethics

As part of routine practice in IAPT Services, all clients are informed that their anonymised information will be stored and may be used for future evaluation purposes. The present study was approved as a service evaluation by the local National Health Service (NHS) Trust and did not require formal ethical approval.

Assessments

Patient Health Questionnaire (PHQ-9) & Generalized Anxiety Disorder (GAD-7)

The two measures routinely used in IAPT services to capture clients' clinical improvement were used to assess treatment outcomes. The Patient Health Questionnaire (PHQ-9) is a 9-item, self-report measure for depression (Kroenke, Spitzer, & Williams, 2001). Scores range from 0 to 27, with higher scores indicating more severe symptoms of depression. The General Anxiety Disorder-7 (GAD-7) assessment is a 7-item, self-report assessment for generalized anxiety disorder (Spitzer, Kroenke, Williams, & Löwe, 2006). Scores range from 0 to 21, with higher scores indicating more severe anxiety symptoms.

Service evaluation form

All practitioners were instructed to consult their clinical notes and record-specific details about each person on their caseload (see Appendix). History of CSA/CPA was recorded, amongst others, on a list of potential presenting problems.

Analysis

Basic descriptive statistics and frequencies were calculated where appropriate. Mann–Whitney U and chi-square tests were performed to explore significant between-group differences. All analyses were performed using SPSS 23.0 software (IBM Corp: Armonk, NY) with significance set at 5%.

Clients were considered recovered at discharge if they were at caseness on at least one measure pre-treatment (i.e., PHQ-9 ≥ 10 & or GAD-7 ≥ 8) and below caseness on both measures, post-treatment (Clark, 2018). Reliable improvement was recorded when a significant reduction was observed between initial and final score in either PHQ-9 (≥ 6) or GAD-7 (≥ 4 ; Clark, 2018). Dropout was assumed when a client had not attended a treatment session, without contacting the service within 2 weeks (Chan & Adams, 2013).

Results

From a sample of 1,315 IAPT clients, 183 (14%) were reported to have a history of CSA/CPA. As shown in detail in Table 1, no significant differences were found on age ($p = .56$) between groups, yet the group of clients with a history of CSA/CPA consisted of more females (74%) and unemployed (33%) individuals.

Table 1. Differences between clients with a history and no history of CSA/CPA

Variables		N (%) or M (SD) No CSA/CPA (1,132)	N (%) or M (SD) CSA/CPA (183)	χ^2 or U, p
Gender	Female	729 (64.6)	135 (74.2)	$\chi^2 = 6.363, p = .01$
Age		39.45 (14)	39.75 (13.3)	$U = 98,655.0, p = .56$
Employment status	Employed	842 (75.2)	121 (66.9)	$\chi^2 = 5.619, p = .02$
	Unemployed	278 (24.8)	60 (33.1)	
Duration of condition (s)	Years	8.6 (10)	15.8 (13)	$U = 62,147.5, p \leq .001$
Number of presenting problems		3.6 (2)	6.8 (2.7)	$U = 35,662, p \leq .001$
Age of onset	Since childhood	261 (24.6)	81 (46.8)	$\chi^2 = 36.862, p \leq .001$
PTSD I ^a	Presenting problem	117 (10.3)	24 (13.1)	$\chi^2 = 1.271, p = .26$
PTSD II ^a	Presenting problem	43 (3.8)	45 (24.6)	$\chi^2 = 109.061, p \leq .001$
Number of attended sessions		10.7 (5.9)	11.5 (6.5)	$U = 97,287.0, p = .17$
Recommended intervention	Brief <4 or group sessions	152 (14.2)	2 (1.2)	$\chi^2 = 77.702, p \leq .001$
	Medium individual (6–12 sessions)	644 (60)	74 (43.8)	
	Long-term individual (>12 session	145 (13.5)	62 (36.7)	
	Counselling	103 (9.6)	25 (14.8)	
T1 intervention ^b	Low intensity	486 (42.9)	61 (33.3)	$\chi^2 = 5.978, p = .05$
	High intensity	635 (56.1)	120 (65.6)	
	Other	11 (1)	2 (1.1)	
T2 Intervention ^b	Low intensity	138 (12.2)	5 (2.7)	$\chi^2 = 18.873, p \leq .001$
	High intensity	981 (86.7)	172 (94)	
	Other	13 (1.1)	6 (3.3)	
Step-up rate	Remain low intensity	124 (11)	5 (2.7)	$\chi^2 = 17.169, p = .01$
	Remain high intensity	613 (54.2)	116 (63.4)	
	Step-up to high intensity	360 (31.8)	56 (30.6)	
PHQ-9	T1	16.3 (6.1)	17.7 (5.7)	$U = 90,986.5, p = .01$
	T2	9.4 (7.2)	10.9 (7.2)	$U = 90,306, p = .01$
GAD-7	T1	14.8 (4.5)	15.4 (4.9)	$U = 98,145.5, p = .25$
	T2	8.4 (6.1)	9.9 (9)	$U = 89,219.5, p = .01$
Recovery	Achieved	603 (53.3)	77 (42.1)	$\chi^2 = 7.902, p = .01$
Reliable Improvement	Achieved	847 (74.8)	128 (69.9)	$\chi^2 = 1.955, p = .16$
Discharge status	Planned	833 (74.2)	126 (68.9)	$\chi^2 = 2.286, p = .13$

Note. T1: Time 1 – first treatment session, T2: Time 2 – last treatment session.

^aPTSD I is based on single incident/trauma & PTSD II on prolonged and repeated trauma.; ^bLow intensity: guided self-management, self-help (book), behavioural activation, mindfulness group therapy; High Intensity: cognitive behavioural therapy, counselling, couples therapy for depression, interpersonal psychotherapy, brief psychodynamic psychotherapy.

Clients with a CSA/CPA history were more likely to present mental health difficulties since childhood (47%) with the average duration of condition being almost double in years ($M = 15.8$, $SD = 13$), in comparison with clients who did not have a reported history of CSA/CPA ($M = 8.6$, $SD = 10$). Greater number of presenting problems ($M = 6.8$, $SD = 2.7$) and higher rates of PTSD I (13%) and PTSD II (25%) were identified in the CSA/CPA group, in comparison to the rest of the sample (PTSD I: 10%; PTSD II: 4%). Only PTSD II, which is based on prolonged and repeated trauma, was significantly different between two groups. PTSD I, based on a single traumatic incident, did not reach significance ($p = .26$).

In regard to the intervention provided, although number of attended appointments did not significantly differ between groups ($p = .17$), clients with a CSA/CPA history were more frequently recommended for longer-term (>12 sessions), individual therapy (37%) and were more likely to receive high-intensity therapy, both in the first (66%) and last (94%) allocated step. In addition, clients with a CSA/CPA history were less likely to remain in a low-intensity intervention (2.7%) and more likely to remain under a high-intensity treatment (63.4%) throughout their treatment journey, in comparison to clients with no history of CSA/CPA (11% and 54.2%). Finally, regarding treatment outcomes, despite the fact that there were no significant differences between groups in reliable improvement ($p = .16$) and discharge status ($p = .13$) recovery rate was significantly lower for those with a history of CSA/CPA (42%) in relation to the group without such adverse experiences recorded within their presenting problems (53%).

Discussion and conclusions

To our knowledge, this is the first study using a large sample to evaluate the history of sexual and physical abuse in IAPT clients. Our findings showed that 14% of IAPT clients were reported to have a history of CSA/CPA. In contrast with the rest of the IAPT sample, clients with a reported history of CSA/CPA had a longer duration of presenting problems, earlier age of onset, greater PTSD co-occurrence, were more likely to receive high-intensity treatment, and presented a lower recovery rate in relation to clients with no such recorded history.

The prevalence of reported CSA/CPA in our study appears to be lower in relation to previous studies conducted in the IAPT setting (25%: Fischer et al., 2018; 27%: Hepgul et al., 2016). This could be attributed to methodological differences as no trauma-specific questionnaire was administered to evaluate the prevalence of CSA/CPA, such as the Childhood Trauma Questionnaire (CTQ-SF; Bernstein et al., 2003). Instead, identification was reliant on clinicians' reports, in our effort to present a naturalistic description of CSA/CPA prevalence among clients accessing IAPT. In addition, clinicians were asked to list clients' presenting problems, and not traumatic life experiences specifically, which may have also led to underreporting.

A recent study using trauma-specific questionnaires reported that although 76.9% ($n = 40$) of the sample experienced a traumatic event and 28.3% of those met criteria for PTSD, the majority were initially referred for mixed anxiety and depression (Thomlinson et al., 2017). Coupled with our findings on low CSA/CPA prevalence as reported to clinicians, this highlights the high risk of adverse life experiences, the meaning derived from such experiences, and potentially symptoms of PTSD, being left unacknowledged, despite the significant impact on treatment course and outcomes (Thomlinson et al., 2017).

As expected, clients with a history of CSA/CPA were presented with significantly higher baseline symptom severity, that could explain why this cohort of clients presented lower recovery rates in relation to clients with no such history. Furthermore, the CSA/CPA group of clients presented promising reliable improvement rates, indicating that a substantial majority (69.9%) are responsive to IAPT treatment. Maybe the case that clients with a CSA/CPA history and a high intake severity require lengthier interventions to attain full remission of symptoms.

Given the high complexity, as defined here by multiple presenting problems and increased chronicity, observed in the group of clients with a reported history of CSA/CPA, our study poses questions of if and how effectively IAPT meets the needs of clients with a history of childhood trauma. Currently, IAPT services commissioned with an IAPT Plus specification include a Step 3+ provision for presenting difficulties deemed more complex, that is increased comorbidity, chronicity, and functional limitation outside the traditional remit of IAPT services. Our empirical approach to understanding the needs of this, and all groups, of people who use our services aims to incrementally increase the knowledge base and ultimately inform routine clinical practice.

Our findings suggest the need for more trauma-informed inquiry and perhaps trauma-specific screening tools, to be used at initial assessment. This would facilitate a more sensitive process of detection and clarification of the impact of traumatic events. Trauma-informed supervision and case formulation would also allow therapists to address the impact of traumatic events and potential PTSD symptoms, consequently enhancing successful treatment outcomes (Thomlinson et al., 2017).

To clarify any ambiguity around the actual prevalence of childhood abuse history in the IAPT setting, given its reporting is solely reliant on clinical judgement and clients' disclosure, further research is suggested. More specifically, we recommend the exploration of emotional abuse and neglect, alongside sexual and physical abuse, using well-established questionnaires (e.g., CTQ; Bernstein et al., 2003) to gauge the impact of all types of trauma on IAPT treatment course.

In conclusion, research into the impact of ACEs on treatment course and outcomes from IAPT is limited. These data show that clients who had experienced CSA/CPA, two forms of ACE, report multiple presenting problems and high levels of PTSD comorbidity, greater likelihood of step-up to high-intensity therapy, and lower recovery rates. These findings suggest that IAPT services may be better placed to meet the needs of clients if history of adverse childhood events was more systematically explored and recorded.

Conflicts of interests

All authors declare no conflict of interest.

Author contributions

Irini Laura Verbist, MSc, BSc (hons) (Conceptualization; Data curation; Formal analysis; Investigation; Methodology; Project administration; Software; Visualization; Writing – original draft; Writing – review & editing) Kate Allsopp (Conceptualization; Investigation; Methodology; Project administration; Writing – review & editing) Dale Huey (Conceptualization; Supervision; Writing – review & editing) Filippo Varese (Conceptualization; Methodology; Project administration; Supervision; Writing – review & editing).

Data availability statement

The data that support the findings of this study are available from the first author upon reasonable request.

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Appendix :

Paris ID

Age

Gender

Referrer: (e.g., GP, Psychiatry, etc)

How long have they had their present difficulties? (nearest in years)

Current Step within the service

What kind of psychological intervention would be most appropriate to help this person resolve their problems?

- Appropriate self-help
- Brief structured guided self-help
- Brief intervention with single focus (e.g., behavioural activation)
- Psychoeducation group
- Brief individual therapy (e.g., < 6 sessions)
- Counselling
- Medium-term individual therapy (6–16 sessions)
- Group work
- Longer-term individual therapy (16 or more sessions)
- Other specialist therapy (please specify)
- Team-based intervention (CMHT)

Please indicate the presenting problems (after advising clinical notes) for this client by ticking all that were present.

Continued

Major Depression (moderate or severe low mood)
Low Self-Esteem
Relationship Difficulties
Stress-related Anxiety
Depressed mood (mild or moderate low mood)
Childhood Sexual or Physical Abuse
Panic Disorder
Anger problems
Personality Disorder (including chronic interpersonal difficulties)
Physical Health Problems
Obsessive-Compulsive Disorder
Generalized Anxiety Disorder
Social Phobia
Suicide attempt(s) (over 12 months ago)
Suicide attempt(s) (in last 12 months)
Current Deliberate Self-Harm (non-suicidal intent)
Deliberate Self-Harm (past/over 12 months ago)
Substance Misuse (past)
Substance Misuse (present)
Sexual Difficulties
Post-traumatic Stress Disorder (adult event)
Hypochondriasis/Health Anxiety
Specific Phobia
Post-traumatic Stress Disorder (chronic childhood events)
Eating Disorder (Anorexia Nervosa)
Eating Disorder (Bulimia Nervosa)
Body Dysmorphic Disorder
Complex Bereavement
Psychosis
Bipolar disorder
Other:
Other:
Other:

Thank you for taking the time to complete this.